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A Moral Stance for the Alzheimer's Patient in Parfit, Dworkin and Wilkes

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Alzheimer's disease is one of the leading causes of dementia for the elderly. It has been estimated that 11.3 percent of Americans sixty five years old or over has Alzheimer's--in Britain, 20 percent of people over eighty have Alzheimer's (Dworkin, 219). How to treat the Alzheimer's patient, what to do with him or her, has become a major moral question in medical ethics. In this paper, I will present three possible stances, supported by three different philosophers, towards the Alzheimer's patient. Interpreting Derek Parfit's theories on personal identity, I assume he would conclude both that the Alzheimer's patient is a person worthy of moral consideration and that suicide may be a morally acceptable possibility for the person facing the early stages of the disease. Ronald Dworkin concludes that the Alzheimer's patient is not a person. Since the sane individual is a person, while the demented patient is not one, the sane individual is in a superior position relative to the patient--his or her will to be killed at the late stage of the disease overrides the demented patient's right to life. Kathleen Wilkes argues that when dealing with the Alzheimer's patient, the Aristotelian loss (viz., a non-moral loss) is relevant--discussion on personhood is not relevant. She concludes that the Alzheimer's patient has suffered an Aristotelian loss; the sane, rational persons surrounding the patient should carry out all possible action to compensate the patient for her Aristotelian loss. Finally, after reviewing the previous positions I will present my point of view, concluding that no stance can be taken nor decision made before the actual, individual situation arises.

First, clarification on the Alzheimer's patient:

> Alzheimer's is a disease of physiological deterioration. Nerve terminals of the brain degenerate into a matted plaque of fibrous material. Patients in the late stages of this disease have lost substantially all memory of their earlier lives and cannot, except periodically and in only a fragmented way, recognize or respond to other people, even those to whom they were formerly close (Dworkin, 218).

For the remainder of the paper, **A** will designate the Alzheimer's patient and person **B** will designate the sane predecessor.

The introduction of Advanced Directives to medical ethics created a situation of conflicting interests between **A** and **B.** Advanced Directives are written statements by patients specifying what treatment they want to receive, or avoid, in the event that they later become unable to make such distinctions. **B** as a person has desires, principles, beliefs and interests that give value or worth to his/her life. Alzheimer's disease will make **A** dependent on others and will dislocate him/her from his/her memories and a large degree of his/her desires, beliefs, principles, etc. **B** consents to the use of Advanced

Directives for himself/herself to be killed at the late stage of Alzheimer's disease, on the grounds that the effects of the disease conflict with **B's** principles and strips **B** of desires, beliefs, etc., which give value to his/her life. Meanwhile, **A,** as the late stage Alzheimer's patient, is sometimes capable of ephemeral interaction with his/her relatives (when he/she remembers them) and of occasional fleeting memories. Otherwise, **A** is limited to living an ever-present and capable of simple pleasures. The moral question raised is whether **B's** right to autonomy--to act according to her beliefs, etc.--in making the decisions overrided **A**'s right to life.

Derek Parfit

Parfit begins with a Lockean basis for personhood. To be a person, a being must be self-conscious, aware of its identity, and its continued existence over time. The point of continued existence over time must be further clarified. For **A** at a certain period in time to be the same as person **B** who exists in a period of time previous to that of **A,** there must exist "psychological continuity" from **B** to **A** and some degree of psychological connectedness between the two. Psychological continuity exists if between **A** now and **B** twenty years ago there have been overlapping chains of direct memories. Psychological connectedness exists if **A** now can remember "having some of the experiences **B** had 20 years ago." Parfit is not explicit about what degree of connectedness must exist between **A** and **B** in order for them to be the same person--in the amoeba-type people thought experiment, Parfit suggests that for **A** to be the same person as **B, A** must have more than 50% of B's memories. However, Parfit is explicit in stating that connectedness matters. "Psychological continuity also matters. But we should reject the view that only continuity matters" (Parfit, 229).

Parfit concludes that though **A** is not the same person as **B, A** is nevertheless a person. Establishing the personhood of **A,** Parfit looks at physical continuity, consciousness, identity and continued existence over time. First, Parfit asserts that there is physical continuity. There is no case of branching existence. **A**'s body and brain have evolved and aged, and are currently deteriorating. Though **A**'s brain is not in the same condition as **B**'s brain, the temporal line uniting the two is continuous. Parfit would next hold that **A** is conscious. Though the patient may not remember who the people surrounding him are, she can still communicate verbally with them, let them know her immediate desires and sometimes interact at some superficial emotional level. For example, "Mary [a patient suffering from advanced Alzheimer's disease]... liked most to be held and loved" (Dworkin, 229). In analyzing the patient's identity and continued existence over time, Parfit treats these two questions separately. Since identity is based on continued existence and continued existence depends on what Parfit calls Relation R, by answering the state of Relation R in the patient, Parfit also answers the question of identity; in other words, if there is Relation R, there is identity. By "Relation R" is meant psychological connectedness and/or psychological continuity with the "right kind of cause" (Parfit, 216). By "right kind of cause," Parfit excludes such situations such as when a person's memories are transplanted to another brain (a person is replicated, and so two people hold the exact same memories) and other situations possible only in thought experiments. Parfit holds that **A** is psychologically continuous with **B**, but lacks

strong connectedness. **A** might still have scattered strong memories of the past, but overall, connectedness is less than 50%. Even though **A** is not strongly connected with **B**, **A** is continuous with **B**--Relation R exists, and so **A** has identity.

In this case, the situation of the Alzheimer's patient is similar to the one of amoeba-type people described in one of Parfit's thought experiments (Parfit, 302). In this example, imaginary people reproduce by natural division, giving each individual in the next generation half the characteristics of the parent. Parfit points out that the quinquagesima generation will be psychologically continuous with the parent in the first generation, but will hold no psychological connectedness with the parent. In Parfit's view, continuity and some degree of connectedness, taken together, are sufficient to establish identity: he would conclude that **A** has identity. Since **A** has met the requirements listed above (is physically continuous and conscious, has identity and continued existence over time), Parfit would conclude **A** is a person.

The next issue to be settled is whether **A** is the same person as **B.** Parfit would argue they are not the same person (Parfit, 229). Though there is psychological continuity, the lack of enough psychological connectedness (having more than 50% of **B**'s memories) separates **A** from **B.** In this view, for **B** to will the death of **A** would be tantamount to **B** willing the death of another person. **A** as a person has some degree of beliefs, desires, etc. On a first look, killing **A** deprives her of her degree of beliefs, desires, etc. and so is wrong. However, defining the right to life is difficult, according to J. J. Thompson: the right to life is the right not to be killed unjustly. If **B**'s degree of beliefs, intentions and desires are superior to those of **A**, it could be argued that it is just for **B**'s will to kill **A**, to overrule **A**'s right to life. Parfit seems to suggest that if it is essential for **B** not to live as **A**, a less conflictive action would be for **B** to prevent **A** from becoming, e.g., for **B** to commit suicide. In this circumstance, **B** would be in complete control of the autonomous decision; no *de facto* interests (i.e., what is in the individual's advantage) would conflict. Whether suicide is morally wrong will not be addressed in this paper; it is merely presented as an option for **B**.

Ronald Dworkin

Dworkin contrasts the issues of autonomy, beneficence and dignity between **A** and **B** and concludes that the late stage Alzheimer's patient is essentially the same as a consistent, vegetative state. The patient **A** can be justifiably killed if willed by person **B.** An autonomous individual is one who is capable of making rational and unconstrained decisions and then acting accordingly. An individual is rational when she is capable of choosing the best means for some chosen ends. An individual is rational when he is capable of choosing appropriate ends.

Dworkin concludes that **B**'s will that **A** be killed should be respected even if it contradicts **A**'s desire to live. He argues that late stage Alzheimer's patients' contradicting demands show no sense of self and no discernible short-term aims. Consequently, they do not have capacity to make autonomous decisions. It is supposed that the sane individual **B** does show rationality and capacity for autonomy. Dworkin introduces a notion he calls the doctrine of precedent autonomy. The doctrine holds that **B**'s--the competent person's--right to autonomy requires that his or her past decisions about how

he or she is to be treated if he or she becomes demented be respected--even if they contradict the desires **A** has at that later period. This doctrine takes into consideration that fact that different persons will have different degrees of rationality--the individual may be able to make decisions, but not necessarily be able to chose the best means for an ends. Dworkin concludes that the doctrine of precedent autonomy justifies that in the case of a person **B** who left a will to be killed when at the late stages of Alzheimer's, his will should be carried out.

Beneficence is defined as the right to be taken care of and decisions be made in the person's best interests when he is no longer capable of them himself. In the case of the Alzheimer's patient, beneficence provides for him experiential interests. By experiential interests is understood the ability to enjoy comfort and reassurance; by critical interests is meant intentions, attachments and acts that make a life valuable. While the Alzheimer's patient is only capable of experiential interests, the sane person is capable both of experiential and critical interests. It is the capacity for critical interests that makes the same person's life unique and valuable. On the section on beneficence, Dworkin concludes that **A**'s right to receive beneficence is outweighed by his predecessor's right to make autonomous decisions. In his explanation, Dworkin makes use of the notions of critical interests and experiential interests. While **B** has both interests, **A** is only capable of experiential interests. Dworkin states that "... they have no sense of a whole life, a past joined to a future, that could be the object of any evaluation or concern as a whole" (Dworkin, 230). The "childish pleasures of dementia" are essentially the same as a consistent, vegetative state. Critical interests belong to a higher order to those of experiential interests and so override the latter. The sane person's (**B**'s) will to be killed when at the late stages of Alzheimer's manifest concerns for critical interests and so outweigh person **A**'s desire for life, which only express an experiential interest.

This part of Dworkin's argument resembles what some call the Doctrine of Swine objection to utilitarianism and Mill's consequent response. The Doctrine of Swine states that it is wrong to merely pursue bodily pleasure as an ultimate ends; to do so reduces persons to the level of swine, or generally to that of animals. The previous objection is aimed at a utilitarianism that only considers quantity of pleasure in defining utility--more pleasure is better than less pleasure. In responding to the objection, Mill redefines utilitarianism by distinguishing between quantity and quality of pleasure. There are different qualities of pleasure, bodily pleasures and intellectual pleasures; the latter pleasures are superior to the former and are the ones pursued by more evolved persons. Experiential interests are concerned with bodily pleasures--comfort and reassurance can be satisfied by physical well being and security. Critical interests are concerned with intellectual pleasure--intentions, attachments, beliefs, etc., belong to the intellectual category. By granting **B** both interests and restricting **A** to experiential interests, Dworkin implicitly raises **B** to the level of a "utilitarian" or "Millian" person and lowers the Alzheimer's patient to the level of swine. Thus, on the grounds of **A**'s inferiority with respect to **B,** Dworkin justifies that the Alzheimer's patient be killed if willed by person **B.**

Dignity is the intrinsic worth persons have for the mere fact of being persons, for being ends in themselves, for having intrinsic value or worth. Dworkin defines dignity as respecting the inherent value of a human life. He concludes that if **B**'s dignity is to be respected, his will to kill **A** must justifiably outweigh **A**'s desire for life--by living, **A** desecrates **B**'s dignity. Dworkin argues that the Alzheimer's patient has no dignity because " ... the patient himself suffers no distinctive distress of indignity..." (Dworkin, 235). He moves on to state that "it seems dubious that the demented have any general right to dignity..." (Dworkin, 234). It is presupposed that **B**, being sane, has dignity. By not fulfilling **B's** will to die, his dignity is being violated, causing severe mental pain, distress, self-contempt and loathing. Meanwhile, by fulfilling **B's** will, no harm is done to **A** since she has no dignity. Dworkin shows that the holding of a value such as dignity is sufficient to make the sane person's will to die prevail over the patient's right to live.

Kathleen Wilkes

Wilkes acknowledges the notion of personhood as being relevant in some philosophical discourse, and she uses Dennett's six conditions for personhood. However, Wilkes believes that personhood is not relevant when discussing the Alzheimer's patient. Personhood is a matter of "decree and degree"; in other words, it can be reached by satisfying some of the six conditions or by potential to reach some of the six conditions. "Perhaps being a person is not such a big deal after all" (Wilkes, 99).

Wilkes concludes that **A** has suffered an Aristotelian loss and should be compensated for it. First, it's necessary to define the Aristotelian principle: "The 'Aristotelian principle,' broadly, claims that every kind K which is not a perfect instance of kind K is in some respect something to be pitied or deplored" (Wilkes, 62). Wilkes gives the example of a puppy born with a twisted paw, prevented from becoming a sheep dog. Similarly, a bird born with a malformation in its wing and unable to fly, or a child born with a brain hernia or mental retardation fit this "pitied or deplored" situation. Wilkes claims that this position is not moral; rather, it is a feeling of waste, of loss: "... the loss strikes us as a much greater one--in part because the activities which are denied to the radically impaired seem more valuable [in the case of humans] ..." (*Ibid.*). Wilkes compares this feeling of distress to an acute sense of aesthetics.

Wilkes argues that the Alzheimer's patient suffers an Aristotelian loss. Unlike Aristotelian losses by infants or fetuses (in which the latter are not aware of their loss), that suffered by the Alzheimer's patient is much more tragic, since the gradual deterioration of the brain allows **A** to be aware of the process she undergoes. Adding to the general tragedy, people surrounding **A** witness her gradual deterioration, contrasting what she was (**B**) and what she is, lamenting what she has ceased to be (**B**) and what she could have been. The loss suffered by the Alzheimer's patient is his inability to engage in activities, to participate in the relationships with others and with the world that defined him as an individual, to pursue projects he had in mind: "... his concerns have been frustrated, possibilities cut off..." (Wilkes, 95). Wilkes's argument is rather obscure. She argues that the Aristotelian loss suffered by the Alzheimer's patient forces the people surrounding him or her to take a stance--in this case, the stance taken by the people

surrounding **A** functions like a reaction or a response to the loss suffered by **A.** The stance taken towards **A** endows **A** with Dennett's third condition for personhood: "a certain stance or attitude must be taken towards them, a point that introduces the idea that persons are *inter alia,* moral objects" (Wilkes, 23). In other words, in reacting to **A**'s loss, a stance is taken towards her. This means that **A** satisfies the third condition of personhood: "a certain stance or attitude must be taken towards them..." (*Ibid.*). **A** can be seen as a potential person. This endows her with the status of a moral agent notice that **A**'s status as a person generates within us rather than in **A** herself). This new status permits **A** to demand from us that we compensate him.

One step is missing in the previous reasoning: it is unclear why, once we are aware of the Aristotelian loss suffered by **A**, we must take a stance towards **A.** The reason seems to lie in the definition of the Aristotelian principle. According to the principle, an imperfect **K** is "something to be pitied or deplored"; the loss creates in us a feeling of waste, of loss similar to an acute sense of aesthetics. This mixture of feelings compose the stance we take towards **A.** Once this step is added, it can be logically concluded that the existence of the Aristotelian loss demands that we "attempt to eliminate, or if not eliminate at least compensate for, as much of the loss as possible" (Wilkes, 73). Though the patient reaches personhood by satisfying condition 3, what is relevant to Wilkes is not the status itself, but rather the compensation the patient deserves.

Notice that Parfit and Dworkin define persons by necessary and sufficient conditions. For Parfit, if the individual satisfies the conditions of physical continuity, consciousness, identity and continued existence over time, then the individual is a person. Similarly, for Dworkin, if the individual satisfies the conditions of autonomy, critical and experiential interests, and dignity, then the individual is a person. Meanwhile, Wilkes emphasizes the stance taken by other persons to the patient. In doing so, Wilkes makes a relational approach to the issue of personhood.

Based on the assumption that there **is** no *a priori* knowledge, I believe no stance can be formulated regarding the Alzheimer's patient until the particular case has been examined, until the degree of insanity suffered by the patient is determined, and until the role the patient plays in other people's lives is understood. By *a priori* knowledge, I refer to abstract concepts or ideas reached by reason alone and applied to derive universal truths or principles. These truths or principles can then be applied to particular situations in the world to reach an understanding of reality.

Agreeing with much recent feminist thought on an "ethic of care," I believe every moral situation must be seen as unique and independent of previous situations. The ethicist must engage with the situation and, through interaction, decide what the best stance to be taken is. The ethicist cannot determine what the right thing to do is before actually engaging in the problem; the solution cannot be reached through abstraction or reason alone. A universal rule cannot be applied because every particular case is different and deserves close examination. Only through interaction with the problem and the people involved can the ethicist decide what is right. Sometimes there will be no right or wrong, but simply an agreement amongst those involved.

The stance that ought to be taken concerning the Alzheimer's patient will remain unclear until the actual situation arises and the persons involved engage in it. This moral

proposition may seem murky or ambiguous. However, one thing is definitely clear: given the new outlook, the setup of the moral situation must be modified. First, it should not be interpreted as one of conflicting interests between **A** and **B**, but rather one of interpersonal disagreements in the relationships both between **A** and **B**, and of **A** and **B** with the people surrounding them--friends and family. Second, **B** is defined as an individual, not as a relational self. The relational self points to the social nature of *homo sapiens*.. It involves the notion that persons need to engage in praxis, to manipulate the world in order to understand it. A mind unable to interact with others, and hence to grow and develop, loses all its intrinsic value. Note that when listing the elements that give value to **B's** life (desires, principles, beliefs and interests), the relationships of **B** with others are not included as a category. Relationships must be included; **B** as well as **A** must be defined as relational selves. As a relational self, **A** becomes much more valuable than as an individual--**A** not only has some degree of desires, interests, etc., but also plays a role in other people's lives. Those people in turn give **A** importance by interacting with him/her--one more factor that should be considered when dealing with the moral situation. If there is no *a priori* knowledge, Dworkin takes an inappropriate approach to the understanding of personhood through necessary and sufficient conditions; personhood can only be understood at the individual level through interaction with particulars.

Personhood is a relational quality; persons must be seen essentially as relational selves. This realization disqualifies much of the traditional study in the field of Philosophy of Mind. If persons are essentially relational, the pursuit of a reductionist approach to the mind in order to reach a general or abstract understanding of persons is wrong. Notice that in taking a different approach, Wilkes offers an alternative to the problem faced by the Philosophy of Mind. Wilkes offers a new understanding of persons and a new approach to the field.

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